

**REPORT OF SANITATION INSPECTION**  
**INTERDEPARTMENTAL REGULATION OF RESIDENTIAL FACILITIES FOR CHILDREN**  
**TELEPHONE (804) 692-1960**  
**DEPARTMENTS OF EDUCATION; MENTAL HEALTH, MENTAL RETARDATION AND**  
**SUBSTANCE ABUSE SERVICES; SOCIAL SERVICES; AND YOUTH AND FAMILY SERVICES**

Name of Facility: \_\_\_\_\_ Licensed Capacity: \_\_\_\_\_  
Name of Operator: \_\_\_\_\_ Address: \_\_\_\_\_

Building(s) Inspected (Please List): \_\_\_\_\_

**I. General Sanitation**

- A. Approved by Health Department: \_\_\_\_\_ Yes \_\_\_\_\_ No  
B. Describe Violations: \_\_\_\_\_  
\_\_\_\_\_

C. Time given to correct violations: \_\_\_\_\_

**II. Sewage Disposal System** \_\_\_\_\_ Public \_\_\_\_\_ Non-Public

- A. Owned by: \_\_\_\_\_  
B. Approved by Health Department: \_\_\_\_\_ Yes \_\_\_\_\_ No

**III. Water Supply** \_\_\_\_\_ Public \_\_\_\_\_ Non-Public

- A. Owned by: \_\_\_\_\_  
B. Approved by Health Department: \_\_\_\_\_ Yes \_\_\_\_\_ No

**IV. Swimming Pool**

- A. Pool meets Health Department guidelines or local swimming pool ordinance, where applicable: \_\_\_\_\_ Yes \_\_\_\_\_ No \_\_\_\_\_ No Pool  
(Attach a copy of Swimming Pool Inspection Report Form LHS-182 or equivalent)

**V. Food Service Operations**

*Apply The Rules and Regulations of the Board of Health Governing Restaurants*

- A. Type of Semi-public Restaurant Operated by Residential Facility:  
\_\_\_\_\_ Semi-public restaurant serving 13 or more recipients of service  
\_\_\_\_\_ Semi-public restaurant serving 12 or less recipients of service  
B. Approved by Health Department \_\_\_\_\_ Yes \_\_\_\_\_ No  
C. Describe Violations: \_\_\_\_\_  
\_\_\_\_\_

D. Time given to correct violations \_\_\_\_\_  
(Attach a copy of Food Service Inspection Report Form CHS-152)

**VI. Summary**

- A. Specify any additional health hazards observed: \_\_\_\_\_  
\_\_\_\_\_  
B. Time given to correct hazards: \_\_\_\_\_  
C. Do you plan a follow-up inspection to verify correction of the above violation(s): \_\_\_\_\_ If yes, anticipated date \_\_\_\_\_

\_\_\_\_\_  
(Signature of Local Health Director or Designee)

\_\_\_\_\_  
(Mailing Address of Sanitarian)

\_\_\_\_\_  
(Signature of Facility Representative)

\_\_\_\_\_  
(Date of Inspection)

\_\_\_\_\_  
(Telephone Number of Sanitarian)